No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 13 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34070

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 4010

8338

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township).
(c) Name of hospital or institution: Leeds T B M. Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days (Specify whether
In this community 40 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 048
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1605 Prater
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country O

3. (a) PRINT FULL NAME Stoup, Phillip STOUP

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

4. Sex Male O

5. Color or race Hebrew

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs Ann Hebrew

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased Jan. (Month) 15 (Day) 1876 (Year)

8. AGE: Years	Months	Days	If less than one day
65	9	10	hr. min.

9. Birthplace (City, town, or county) Austria (State or foreign country) 4

10. Usual occupation Auto Wrecking

11. Industry or business

MOTHER FATHER

12. Name Stoup, Howard

13. Birthplace (City, town, or county) Austria (State or foreign country) 4

MOTHER

14. Maiden name Unknown

15. Birthplace (City, town, or county) Unknown (State or foreign country) 4

16. (a) Informant Leeds T B M. Hosp

(b) Address Leeds, Missouri

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-27-41 (Month) (Day) (Year)

(c) Place: burial or cremation SHEFFIELD

18. (a) Signature of funeral director J. Louis Funeral Home

(b) Address 3400 Woodland K C Mo

19. (a) 10/27/41 (Date received by local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 25
year 1941 hour 6-7 minute 42 P.M.

21. I hereby certify that I attended the deceased from October 22, 1941, to October 25 1941; that I last saw him alive on October 25, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Uraemia	
Due to Chr. nephritis	
Due to	
Other conditions (Include pregnancy within 3 months of death) Pulmonary Tbc.	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature C. C. Hamilton (M. D. or other) 8
Address U. C. Th. Hospital Date signed

(Licensed Embalmer's Statement on Reverse Side) K C Mo.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

.....Myself....., Registered Apprentice No.....

working under my personal supervision.

Signed.....Burt Legan.....

Licensed Embalmer No. 3979

P. O. Address. K. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.